CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
DELAWARE BOARD OF NURSING

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

APPLICATION FOR REINSTATEMENT OF LAPSED NURSING LICENSE

1. This form is to be completed, including the affidavit, and returned with the non-refundable fees. (refer to the enclosed fee schedule)
2. If you have practiced 1000 hours or more in the past five years or 400 hours in the past two years, complete and sign the enclosed reference request form and forward to your nursing employer(s) who can verify your most recent six months of nursing employment. They will mail the completed form directly to this office; **OR**
3. If you have been inactive in nursing for five or more years, you must present evidence of successfully completing an approved refresher program within a two-year period prior to submitting this application.
4. You must complete the verification of continuing education form indicating the courses/programs you have completed within the past two years. RNs are required to submit 30 contact hours, and LPNs are required to submit 24 contact hours.
5. If your name has been changed since you were last licensed in Delaware, enclose a copy of your marriage certificate or court action.

The Board office must receive items submitted for the Board to consider at its meeting no later than two full business days before the meeting. In order to be considered at a Board meeting, license applications must be complete two full business days before the meeting. A complete application is one that includes all required documentation and correct payment.

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your license.

➢ DECLARATION OF PRIMARY RESIDENCE

I Hereby declare my State of Primary Residence to be _____.

➢ **You MUST attach a photocopy of your driver's license or identification card issued by the State Division of Motor Vehicles.**

NAME _____
Last First Middle Maiden

ADDRESS_____
Street City State Zip Code

Email Address _____

PHONE #_____ **S.S. #** _____ **RN [ ] LPN [ ]**

DELAWARE NURSING LICENSE NUMBER _____ **YEAR ISSUED** _____

LICENSED IN WHAT OTHER STATE(S)?_____

List names and full addresses of all nursing employers and dates of employment in the past five years.

NAME	ADDRESS	DATES

1. Has any license to practice nursing ever been surrendered, suspended, revoked, probated, or otherwise disciplined?
[ ] NO [ ] YES **If yes, in what states?**

_____

2. Is any license to practice nursing currently under investigation?
[ ] NO [ ] YES **If yes, in what state(s)?**

_____

3. Have you ever been denied licensure in Delaware or any state?
[ ] NO [ ] YES **If yes, in what state(s)?**

_____

4. Have you ever been convicted of or entered a plea of guily or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction?
[ ] NO [ ] YES **If yes, submit a certified copy of your criminal history record.**

5. Are you now dependent upon the use of alcohol, stimulants, or habit-forming drugs?
[ ] NO [ ] YES

If you answered yes to questions 1 - 5, please explain in a separate letter and attach the corresponding legal documents.

_____

MINIMAL HOURS

Delaware law requires that you meet the practice requirement within the past five years to obtain licensure in Delaware.

Practice Requirement (You must check at least one)
I have practiced nursing AT LEAST:
_____ 1,000 hours in the past five years
_____ 400 hours in the past two years
_____ Completed a Refresher Course in the past two years (submit evidence)
_____ Completed an alternate supervised practice plan (submit evaluation)
_____ None of the above.

APPLICATION FOR TEMPORARY PERMIT:

There is a fee of $30.00 for each temporary permit request, in addition to the licensure fee. There is no charge for permit extensions.

Complete the temporary permit application if employment in Delaware has been offered. **DO NOT BEGIN EMPLOYMENT OR ORIENTATION IN DELAWARE WITHOUT A TEMPORARY PERMIT OR DELAWARE LICENSURE. ADVANCED PRACTICE NURSES MUST COMPLETE AN ADDITIONAL APPLICATION.**

EMPLOYER, TRAVEL AGENCY AND/OR FACILTY::_____

DATE TO BEGIN:_____EMPLOYER'S PHONE NUMBER:_____ _

NAME RECRUITER/CONTACT PERSON:_____ _

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Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your license.

_____

A F F I D A V I T

To Be Notarized:
County of: _____ State of:_____

_____, being duly sworn, stated that he/she is the person referred to in the foregoing application for reinstatement of a lapsed license to practice nursing in the State of Delaware; that the statements contained herein are true and that he/she has read and understands this affidavit.

_____
Signature of Applicant

Sworn before me on this _____ day of _____, in the year _____.

_____ _____
Notary Public My commission expires

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TO: APPLICANTS FOR LICENSURE BY REINSTATEMENT

FROM: Iva J. Boardman, RN, MSN, Executive Director
Delaware Board of Nursing

RE: Application Fee Schedule and Instructions for Reinstatement

DATE: Effective as of July 1, 2006

Please review the following instructions carefully before submitting your application to our office.

1) Using your license number, include the fee listed for the month that you are submitting your application. **There is a fee of $30.00 for each temporary permit request, in addition to the licensure fee. There is no charge for permit extensions.**
Checks should be made payable to the State of Delaware. All fees are non-refundable. Please contact the Board office at (302) 744-4516 or 744-4515 if you have questions. Thank you.

2) **MUTUAL LICENSURE RECOGNITION INFORMATION - The following states have implemented the Nurse Licensure Compact (Arizona, Arkansas, Colorado, Delaware, Florida, Idaho, Indiana, Iowa, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oregon, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia or Wisconsin.) Indiana and New Jersey have passed the legislation but have not yet established implementation dates. It is anticipated that more states will pass the legislation extending the multi-state practice privilege throughout the country.**

The compact creates mutual recognition of nursing licenses among the compact states listed above. A nurse living in a compact state can practice nursing in any other compact state without obtaining a license in that state. The nurse licensure compact works like the driver's license. A driver's license allows you to drive in any compact state as long as you have obtained a license in your state of residence.

IF YOU LIVE IN A COMPACT STATE, the following rules apply:

1) **The compact requires that you hold a license only in your declared state of residence to practice in all other compact states. You must apply for licensure by examination in your home state of residence.**
2) **If Delaware is not your declared state of residence, you need to now apply for licensure in your declared state of residence, since the licenses that you carry in other compact states will become invalid. Should you change residence to another compact state, you will need to obtain a license in your new state of residence and relinquish the license from your previous state of residence.**
3) **If you move to a non-compact state, your license in the previous compact state will remain valid for practice only in that state. It will no longer carry the multi-state practice privilege, since you no longer live in a compact state.**
4) **You will continue to need to seek licensure in all non-compact states in which you practice.**

REGISTERED NURSES: Please refer to your Delaware license number to determine your licensure "Group" below:

GROUP "A" – LICENSE NUMBERS L1-000001 TO L1-0017000

Licensure through 2/28/2007

July, 2006	$77.00	January, 2007	$145.00
August, 2006	$73.00	February, 2007	$141.00
September, 2006	$69.00	March, 2007	$137.00
October, 2006	$65.00	April, 2007	$134.00
November, 2006	$62.00	May, 2007	$130.00
Licensure through 2/28/2009		June, 2007	$126.00
December, 2006	$149.00		

GROUP "B" – LICENSE NUMBERS L1-0017001 – L1-0024000

Licensure through 5/31/2007

July, 2006	$88.00	January, 2007	$65.00
August, 2006	$84.00	February, 2007	$62.00
September, 2006	$81.00	**Licensure through 5/31/2009**	
October, 2006	$77.00	March, 2007	$149.00
November, 2006	$73.00	April, 2007	$14500
December, 2006	$69.00	May, 2007	$141.00
		June, 2007	$137.00

GROUP "C" – LICENSE NUMBER L1-0024001 – AND UP

Licensure through 9/30/2007

July, 2006	$10300	January, 2007	$81.00
August, 2006	$100.00	February, 2007	$77.00
September, 2006	$96.00	March, 2007	$73.00
October, 2006	$92.00	April, 2007	$69.00
November, 2006	$88.00	May, 2007	$65.00
December, 2006	$84.00	June, 2007	$62.00

LICENSED PRACTICAL NURSES:

Licensure through 2/28/2008

July, 2006	$123.00	January, 2007	$100.00
August, 2006	$119.00	February, 2007	$96.00
September, 2006	$115.00	March, 2007	$92.00
October, 2006	$111.00	April, 2007	$88.00
November, 2006	$107.00	May, 2007	$84.00
December, 2006	$103.00	June, 2007	$81.00

Rev. 06/06

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REFERENCE FORM FOR LICENSURE PURPOSES ONLY

The applicant must complete the front page of this form and forward it to **all of their employer(s) who comprise the most recent six months of nursing practice. If you were a new graduate within the past year and have not been employed as a nurse for at least six months, please also send this form to your school of nursing for completion, in addition to any nursing employers.** The employer/school of nursing will complete the form and return it directly to the Board office. **WE CANNOT ACCEPT THE FORM IF IT IS RETURNED BY THE APPLICANT.**

Name of Applicant _____
(Please Print) (Last) (First) (Maiden)
Applicant's Address _____
(Street) (City) (State) (Zip Code)

RN _____ LPN _____ Social Security # _____

EMPLOYER:_____ (___)_____
Name of Employer Telephone Number

_____
Address

_____
City State Zip Code

The applicant whose name appears above has applied for licensure in Delaware. Please complete this form on the reverse side and return it to the **Delaware Board of Nursing**. Thank you for your assistance.

Iva J. Boardman, RN, MSN
Executive Director

FROM: Applicant for Delaware Licensure
RE: Release Statement

As an applicant for licensure in the State of Delaware, I hereby authorize release of reference information relative to my employment/nursing education at the above named institution.

SIGNATURE: _____

DATE: _____

ARTICLE VI, SECTION 5.1:2 of the Rules and Regulations of the Delaware Board of Nursing mandates a reference from the applicant's immediate past employer(s) for the most recent six months of nursing employment. In the event of no previous nursing employment, the reference shall be provided from the Director of the applicant's approved nursing education program. Any unsatisfactory reference shall be brought to the attention of the Board for review.

A. EMPLOYER: **Please complete Section A and sign and date at the bottom of the page.**

The individual named on the front of this reference request form was/is employed as an:

LPN _____ RN _____ APN _____

FROM: _____ TO: _____
Month/Day/Year Month/Day/Year

Based upon this individual's performance, would you recommend this individual for licensure?

YES _____ **NO** _____ **CURRENTLY EMPLOYED** _____

NOTE: If you checked no, please state specifics. Your answer is a factor in determining eligibility for Delaware licensure.

_____

_____

If you were a new graduate within the past year and have not been employed as a nurse for at least six months, please also send this form to your school of nursing for completion, in addition to any nursing employers.

B. SCHOOL OF NURSING: Please complete Section B. and sign and date below.

The individual named on the front of this reference request form completed the RN _____ or PN_____ educational program at:

NAME OF SCHOOL: _____ GRADUATION DATE: _____

MUST BE SIGNED AND DATED

Name of Employer/School of Nursing_____

Name of Person Completing Form _____

Title_____Signature_____

Telephone #_____ DATE _____

RETURN FORM TO:

DELAWARE BOARD OF NURSING
861 SILVER LAKE BLVD, CANNON BLDG., SUITE 203
DOVER, DE 19904

DO NOT FAX THIS FORM

Rev. 06/04

DELAWARE BOARD OF NURSING

Verification of Continuing Education

COMPLETE THIS FORM AND SUBMIT WITH YOUR REINSTATEMENT APPLICATION.

Instructions:

1) Please print or type **ALL** information. **THIS FORM CANNOT BE FAXED!**
2) List complete dates (M/D/Y) as stated on certificate, complete course names, complete names of providers (not the presenters) and number of contact hours awarded for continuing education in the chart below. Additional space is on page 2. Initials for courses and providers cannot be accepted. **Continuing education must be listed on this form.**
3) **Sign and date in the space provided.**

PLEASE NOTE: YOU MUST SUBMIT COPIES OF EACH CERTIFICATE IN ORDER TO RECEIVE CREDIT FOR THE COURSE.

Name: _____ DE Nursing License Number:
Last First MI

Address: _____ City _____ State _____ Zip _____

CONTINUING EDUCATION REQUIREMENT: (please mark appropriate box)

[ ] I am a Licensed Practical Nurse and am required to submit 24 hours of continuing education.
[ ] I am a Registered Nurse and am required to submit 30 hours of continuing education.

Date M/D/YR	**Name of course/program/conference etc. NO INITIALS**	**Name of Provider NO INITIALS (NOT Presenter or Approver)**	**Number of Contact Hours**

Please note: 1 college credit = 5 contact hours

Are you enrolled in a nursing degree program? YES _____ NO _____

***** PLEASE SIGN AND DATE FORM ON REVERSE SIDE*****

Date M/D/Yr	**Name of course/program/conference etc. NO INITIALS**	**Name of Provider NO INITIALS (NOT Presenter or Approver)**	**Number of Contact Hours**

Please note: 1 college credit = 5 contact hours

Are you enrolled in a nursing degree program? YES _____ NO _____

By my signature below I certify that the information contained in this document is true and correct to the best of my knowledge.

SIGNATURE:_____ DATE:

This form may be duplicated as needed